Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed A Khalifa

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-13-3065-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…as provided by DWC rule 133.250(c)(2) please accept this letter as our request for reconsideration."

Amount in Dispute: $25.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 19, 2013	99080	$25.50	$25.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §404.155 establishes cost for copies of medical records by an ombudsman.
3. 28 Texas Administrative Code §134.120 sets out guidelines for reimbursement for medical documentation.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication
   - 18 – Duplicate claim/service

Issues

1. Did the requestor submit disputed services per applicable Division guidelines?
2. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 29, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. Texas Labor Code §404.155(a) – (b) states, "At the written request of an ombudsman designated under this subchapter who is assisting a specific injured employee, a health care provider shall provide copies of the injured employee's medical records to the ombudsman at no cost to the ombudsman or the office. (b) The workers' compensation insurance carrier is liable to the health care provider for the cost of providing copies of the employee's medical records under this section. The insurance carrier may not deduct that cost from any benefit to which the employee is entitled." Therefore the disputed charges will be reviewed per applicable Division of Workers' Compensation rules and guidelines.
3. Per 28 Texas Administrative Code 134.120 (f) "The reimbursements for medical documentation are: (5) narrative reports: (1) copies of medical documentation--$.50 per page." This amount multiplied by total number of units (51 pages) equals $25.50. The amount is payable to the requestor.
4. Disputed service does meet requirements of applicable Division rules. The requestor is seeking $25.50. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $25.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $25.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 18, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.